GENERAL INSTRUCTIONS
DDE-2447 Incident Report of Caregiver Misconduct and Injuries of Unknown Source

This form is used to report any alleged incidents of caregiver misconduct (client abuse or neglect or misappropriation of client property). The Department reviews the information provided on this report to determine whether or not to open an investigation of the incident. In order for the Department to make this determination, the DDE-2447 must be completed in its entirety. The following may be used as a guide when completing the DDE-2447.

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ENTITY INFORMATION

It is intended that the entity or facility named is the entity responsible for the care of the alleged victim. All responses regarding the report will be sent to the administrator and address listed in this section.

ENTITY TYPE CODES

Code	Entity Type	Code	Entity Type
34	Emergency Mental Health Service Programs	111	EMTs – intermediate
40	Mental Health Day Treatment Services for Children	112	EMTs – paramedic
61	Community Mental Health Developmental Disabilities/AODA	113	First responder/defibrillation
63	Community Support Program	124	Hospitals
82	Certified Adult Family Homes	127	Rural Medical Centers
83	Community Based Residential Facilities	131	Hospices
88	Licensed Adult Family Home	132	Nursing Homes
89	Residential Care Apartment Complexes	133	Home Health Agencies
110A	Ambulance Service Entities	134	Facilities for the Developmentally Disabled
110B	EMTs – basic	000	Other: (specify)

SUMMARY OF INCIDENT

*** Briefly describe the incident in the space provided below.**

Summarize the incident here, even if more details are attached.

*** Explain what was done, upon learning of the incident to protect the client(s) from further abuse, neglect or misappropriation of property.**

Describe the steps the entity has taken to ensure that clients are protected from subsequent episodes of misconduct while a determination on the matter is pending.

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*** Indicate when the incident occurred.**

Include the month/day/year and time the incident occurred. If the exact day is not known, provide an approximate date, such as the week of March 1 or the month of March.

*** Check the specific location where the incident happened.**

If the incident happened at another location indicate the specific location.

LAW ENFORCEMENT INVOLVEMENT

Check if law enforcement was contacted. Attach a copy of the law enforcement incident report if available, otherwise fill in the officer's name, department, address, telephone number, and if available the case number.

ALLEGED VICTIM INFORMATION

Include the alleged victim's name, date of birth, gender, address, and telephone number. If the alleged victim has been adjudicated incompetent, is under age 18, or has an activated Power of Attorney for Health Care, include the name, address and telephone number of parent, guardian or legal representative.

ACCUSED CAREGIVER INFORMATION

Include the accused caregiver's name, social security number, position or title at time of incident, date of birth, gender, home address and home telephone number. If the accused caregiver is currently employed by an entity other than the reporting entity include the name, address and telephone number of this employer if known. If the accused caregiver is under age 18 provide the name, address and telephone number of a parent or guardian. If there is more than one accused caregiver, complete a separate DDE-2447 form for each accused caregiver.

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REPORTER AND ANY OTHER INDIVIDUALS WHO MAY HAVE SPECIFIC KNOWLEDGE OF THE INCIDENT
Include all individuals with specific knowledge of the incident. Include the individual's name, address and telephone number. Check whether or not the individual is an entity employee. Include the individual's position in the entity or relationship to the victim. If additional space is needed, attach an additional page.

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SUMMARIZE BELOW OR ATTACH A COPY OF THE ENTITY'S INVESTIGATION OF OR INQUIRY INTO THE INCIDENT
Provide information the entity found during its inquiry/investigation. Include any of the following information if it is available and would be helpful in resolving this complaint.

- Staff schedule/roster for date incident occurred
- Personnel records of accused caregiver, e.g. time cards
- Personnel records for staff witness(s), e.g. time cards
- Written statements from the victim, accused and/or witnesses
- Sign off sheets indicating completion of cares pertinent to the incident
- Anything else the entity feels of significance to the incident
- Victim's medical records
- Ambulance run report
- Photos
- Diagram/illustration
- Any available law enforcement documents related to the alleged incident
- Entity's/facility's policies related to the incident

PERSON PREPARING THIS REPORT
Include the name, position or title and telephone number of the person preparing this report. The person preparing this report should also sign and date this form in the space provided.

MAILING INSTRUCTIONS

PLEASE NOTE

If the accused caregiver is a person credentialed by the Department of Regulation and Licensing**, i.e., RN, LPN, MD, etc.,** send the completed form, and any available supporting documentation, with the results of your inquiry, to the following address:

Department of Regulation & Licensing
PO Box 8935
Madison, WI 53708-8935

NOTE: Nurse Aides are regulated by the Bureau of Quality Assurance (BQA), not DRL.
For all other allegations, refer to the following entity-specific mailing instructions.

FEDERALLY CERTIFIED NURSING HOMES AND
FEDERALLY CERTIFIED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Upon the completion of each investigation, send the completed form, any available documentation and the results of your investigation **within 5 WORKING DAYS (Monday - Friday, excluding legal holidays)** of the incident, to the following address**:**

Bureau of Quality Assurance
Caregiver Regulation and Investigation Section
2917 International Lane, Suite 300
Madison, WI 53704

ALL OTHER ENTITIES

Upon the completion of each investigation of the incident, send the completed form, any available documentation, and the results of your investigation, **within 7 CALENDAR DAYS** of the date the entity knew or should have known of the incident. to the following address:

Bureau of Quality Assurance
Caregiver Regulation and Investigation Section
2917 International Lane, Suite 300
Madison, WI 53704

-- Questions about completion of this form may be directed to (608) 243-2019 --

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2447 (Rev. 7-2003)

STATE OF WISCONSIN
Bureau of Quality Assurance

Entity Report No.	CG Report No.

INCIDENT REPORT OF CAREGIVER MISCONDUCT AND INJURIES OF UNKNOWN SOURCE

Completion of this form is required by s. HFS 13.05(3)(a), Wis. Admin. Code. Failure to file a required report may subject the entity to forfeiture or other sanctions specified by the Department under s. HFS 13.05(3)(e), Wis. Admin. Code. Failure to provide complete and accurate information may delay the investigation process. Personal information will be used to investigate the reported incident and the results of the investigation may be shared with other authorized investigative agencies. Disclosure of the caregiver's social security number is voluntary; however, the Department uses that number for the purpose of identification and it is used to correctly place a finding of abuse, neglect or misappropriation of property on the Caregiver Registry.

This form must be completed in its entirety. Additional information may be attached.

ENTITY INFORMATION

Entity/Facility Name		Telephone Number
Address		Federal Provider or Certification Number
City, State and Zip	County	State License, Approval or Registration Number
Administrator's Name		Entity Type Code (see instructions

SUMMARY OF INCIDENT

DESCRIBE the incident briefly in the space provided below. If necessary, attach additional information or documentation.

EXPLAIN what was done upon learning of the incident to protect the client(s) from further caregiver misconduct or injury.

INDICATE when the incident occurred. If you do not know the exact date and time make as close an estimate as possible. Include the date the incident was discovered if other than the date the incident occurred.	Date Occurred	Time Occurred ☐ **AM** ☐ **PM**	Date Discovered

CHECK the specific location where the incident happened.

☐ At your entity

☐ During transport

☐ Another location – EXPLAIN:

LAW ENFORCEMENT INVOLVEMENT

☐ Check if law enforcement was contacted or involved.

Attach a copy of the law enforcement incident report, if available. If not, fill in the information below.

Officer's Name (if available)	Department	Case Number (if available)
Address	Telephone Number	

ALLEGED VICTIM INFORMATION

Name	Date of Birth	Gender ☐ Male ☐ Female
Address	Telephone Number	
City, State and Zip		
If adjudicated incompetent or if under 18, name, address and telephone number of parent, guardian or legal representative.		

ACCUSED CAREGIVER INFORMATION

Name of Accused	Social Security Number - -	
Position/Title of Accused (at the time of the incident)	Date of Birth	Gender ☐ Male ☐ Female
Home Address	Home Telephone Number	
City, State and Zip		
Name, address and telephone number of current employer, **IF OTHER THAN THE REPORTING ENTITY.**		
If under 18, name address and telephone number of parent or guardian.		

REPORTER AND ANY OTHER INDIVIDUALS WHO MAY HAVE SPECIFIC KNOWLEDGE OF THE INCIDENT

If more space is necessary, additional pages may be attached.

Name of Reporter	Telephone Number
Address	
City, State and Zip	Is this person an ENTITY EMPLOYEE? ☐ Yes ☐ No
Reporter's Position in the Entity or Relationship to the Victim	

Name	Telephone Number
Address	
City, State and Zip	Is this person an ENTITY EMPLOYEE? ☐ Yes ☐ No
Position in the Entity or Relationship to the Victim	

Name	Telephone Number
Address	
City, State and Zip	Is this person an ENTITY EMPLOYEE? ☐ Yes ☐ No
Position in the Entity or Relationship to the Victim	

Name	Telephone Number
Address	
City, State and Zip	Is this person an ENTITY EMPLOYEE? ☐ Yes ☐ No
Position in the Entity or Relationship to the Victim	

Name	Telephone Number
Address	
City, State and Zip	Is this person an ENTITY EMPLOYEE? ☐ Yes ☐ No
Position in the Entity or Relationship to the Victim	

SUMMARIZE BELOW OR ATTACH A COPY OF THE ENTITY'S INVESTIGATION INTO THE INCIDENT

☐ Check if copy is attached.

PERSON PREPARING THIS REPORT

Name	Position or Title	
Signature	Date	Telephone Number